Laurel Hicks, Licensed Clinical Social Worker
Confidential Information

Client Name_____ Age_____

Client Date of Birth_____ Gender ____M ____F Social Security # (last four #'s)_____

Education_____

Employer_____

Home Street Address_____

City_____ State_____ Zip_____

Email_____ Client Referred By_____

Phone_____ Text To_____

Appointment Preference Days and Times_____

Emergency Contact_____ Telephone_____

Presenting Problem(s) (include past/present alcohol, chemical or substance use/abuse/dependency)_____

_____

_____

What do you hope to achieve from therapy?_____

_____

Past/Present Medical Care (specify major problems, accidents, hospitalizations and current medications, including psychiatric)_____

_____

_____

Family History (Chemical Dependency, Mental Illness, Violence, Suicide): _____

_____

Client Interests_____

_____

If using Employee Assistance Program (EAP), Authorization #_____ # of sessions_____

Name of the EAP:_____

ALL CLIENTS MUST COMPLETE THE FOLLOWING INSURANCE INFORMATION **(including EAP clients):**

Insurance Policy Holder Name (if different from above)_____

Policy Holder's Date of Birth_____ Policy Holder's SSN_____

Home Street Address_____

City_____ State_____ Zip_____

Phone_____ Email_____ Text To_____

Employer_____

Employer Address_____

Insurance (Primary) Name of Insurance Company_____

Insurance ID Number_____ Group #_____

Provider/Behavioral/Mental Health Phone Number_____

Insurance Address_____

Deductible Amount_____ **How much is met?**_____

Copay or Coinsurance Amount_____ **Pre-authorization Number**_____

OFFICE POLICIES and GENERAL INFORMATION

CONFIDENTIALITY

In compliance with the Code of Ethics of the National Association of Social Workers and state and federal law, all services I provide are kept confidential, except as noted below. As required by social work practice guidelines and current standards of care, I keep records of your therapy. Neither the fact that you are participating in therapy, nor any information disclosed in the therapy sessions will be disclosed except as requested by you and/or when disclosure is required by law as noted in the exceptions below.

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

Legal Issues
Disclosure may be required pursuant to a legal proceeding. If you place your mental status at issue in litigations by yourself, the defendant may have the right to obtain the psychotherapy records and/or testimony by Laurel Hicks, LCSW. In such cases, there are additional and substantially higher fees assessed. You may request a copy of the modified fee schedule if needed.

Confidentiality among family members in treatment
When couples and/or families are in treatment together, different family members may, at times, be treated individually; in these circumstances, confidentiality and privilege do not apply between the couple or the family members. Laurel Hicks will use her clinical judgment if and when revealing such information.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Print Name: _____ **Signature**: _____ **Date**_____

THE PROCESS OF TREATMENT/ASSESSMENTS

Participating in psychotherapy can result in a number of benefits for a client, including improving interpersonal relationships and the resolution of specific concerns and/or problems that led a client to seek treatment.

Working toward these benefits, however, requires effort from the client. Psychotherapy requires a client's very active involvement, honesty, and openness in order to achieve the necessary cognitive/behavioral goals. Laurel Hicks will solicit client feedback during treatment to monitor progress; client honesty and openness can facilitate this process.

The therapeutic process may include discussions of your personal challenges and difficulties, which can elicit uncomfortable feelings such as sadness, guilt, anger and frustration. However, therapy has been shown to have many benefits. It can often lead to better interpersonal relationships, improved work/academic performance, solutions to specific problems, and an increased capacity to manage intense feelings. But, there is no assurance of these benefits. Therapy requires your very active involvement in order to work towards growth. I am committed to this process and work hard for you, and I will ask you to do the same.

Treatment goals may be achieved easily and swiftly or may be slow and even frustrating. There is no guarantee that psychological treatment will yield positive or intended results. Attempting to resolve issues that brought a client to treatment initially, such as interpersonal relationship, may result in changes that were not originally considered or intended.

If a client may benefit from a treatment procedure that Laurel Hicks does not provide, Ms. Hicks is ethically and legally obligated to assist a client in obtaining those treatments.

For the express benefit of the client, at times I may consult with supervisors or colleagues about the best way to provide the treatment that you may need, however, your name and/or other identifying information are never disclosed; a client's identity remains completely anonymous and confidentiality is fully maintained.

If at any time a client needs another professional opinion or wishes to consult with another clinician, Laurel Hicks will assist in locating a qualified practitioner and, with the client's written consent, will provide essential information needed.

A client has the right to terminate treatment at any time. If a client chooses to do so, Laurel Hicks will offer to provide information for other qualified clinicians whose services might be preferred.

I have read, understand, and agree to comply with the above office policies:

Print Name: _____ **Signature**: _____ **Date**_____

BILLING AND INSURANCE INFORMATION

Your payment or co-pay is due at the commencement of each session; please remember to bring this with you to every session as Laurel Hicks has a strict no pay no stay policy. Laurel Hicks requires copayment in cash only.

Telephone conversations, report writing and reading, consultation with other professionals, release of information, extended sessions, etc. will be charged at the standard fee rate, unless otherwise agreed upon.

Clients who carry insurance please note that professional services listed above are rendered and charged to the client and not to the insurance company (only the session fee is charged to the insurance company or EAP).

Clients are personally responsible for the payment of all charges. Payment for any session fees denied or not covered by a client's insurance company is the client's responsibility.

Many clients elect to file third party insurance coverage, including Medicare, for services rendered. As a courtesy, Laurel Hicks will file only primary insurance claims for clients, provided the client authorizes her to do so and provide Ms. Hicks with the necessary information for filing such claims. Filing claims to a client's secondary insurance company is the client's responsibility. The world of health care has experienced a tremendous change in the manner in which insurance companies reimburse for third party payment. Many plans require initial precertification of care before clients can use their insurance benefits, as do the secondary insurance companies. It is the client's responsibility to make sure he/she meets precertification requirements.

If information in reference to primary insurance is inaccurate, the financially responsible person is required to pay the full session fee and address any concerns with his/her insurance company.

Laurel Hicks agrees to file primary insurance claims but if the client's insurance status has changed, lapsed or denied coverage, the client is responsible for the treatment fees in full. The client's signature indicates his/her understanding and acceptance of these terms.

If a client has a balance due, Laurel Hicks may use legal means (court, collection agency, etc.) to recover all fees and collection costs due and payable.

Any court order is an agreement between the client and the courts, not Laurel Hicks and clients are still responsible for payment of all charges.

I have read, understand, and agree to comply with the above billing policies.

Print Name: _____ **Signature**: _____ **Date**_____

CANCELLATION POLICY IS ENFORCED

One important element for an effective therapeutic outcome is for us both to set our session times as a priority. Cancellations are discouraged for both therapeutic and scheduling reasons. Scheduling a session involves the reservation of time for each client. A minimum of forty-eight (48) hours notice is required for rescheduling or canceling a session. When a client fails to cancel a scheduled session 48 hours in advance, the therapist cannot use that time for another client. Therefore, without such notification, a fee of $60 for the unused session will be charged to you, not your insurance carrier. Further, the client will be billed for the cost of collection services in addition to the $60 fee when the provider deems those services necessary.

If you reschedule, there will not be a cancellation time period available for another rescheduled session and you will be billed if you miss the session.

I have read, understand, and agree to comply with the above billing policies.

Print Name: _____ **Signature**: _____ **Date**_____

NOTIFICATION OF CLIENTS RIGHTS – HIPPA

Notification of Client Rights is now required with the passage of the federal "medical records privacy law" known as HIPAA (Health Insurance Portability and Accountability Act). I am required by law to inform you of your rights and secure your signature indicating you have received the HIPPA information. Laws such as these are important, but also complex and in my **HIPPA** document I have tried to inform you about your rights in a plain, simple language. A document outlining HIPPA compliance is available and may be obtained at the time of your intake assessment. Please feel free to ask questions about the Health Insurance Portability and Accountability Act of 1996 (HIPPA).

Your signature below constitutes your knowledge of your protected health information (HIPPA).

Print Name: _____ **Signature**: _____ **Date**_____

YOUR INFORMED CONSENT TO CARE

I have provided this information to you in the hope of fully informing you about the policies of my office and some of the parameters of care you will receive here, such as the importance of confidentiality. Psychiatric and psychological care, like other things in life, offers no absolute guarantee of success and there are limitations to any form of care offered a client. Since such limitations are always a function of the particular problem in question, I invite you to discuss your treatment plan with me. After we have met to discuss your concerns, I will construct an individualized treatment plan and share it with you so that you and I have our plan for what problems we are going to solve and how.

Please feel free to discuss any of these matters with me in more detail. By signing below, you acknowledge having read, understood, and agreed to these policies and procedures. Your signature acknowledges your informed consent for care.

Print Name: _____ **Signature**: _____ **Date**_____

LAUREL HICKS, MSW

Licensed Clinical Social Worker, Licensed Clinical Additions Counselor
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Welcome to my practice!
The following information is provided to my clients to assist you in understanding policies and procedures at my office. I strive to provide you care, which is both comfortable, and of the highest quality. Please do not hesitate to ask questions of me at any time about these matters.

Appointments
I typically schedule my own appointments for clients but sometimes a clerical staff person will do so when appointment changes come to pass.

Since clients are seen by appointment only, **the appointment time given is reserved for you.** My cancellation policy is that a no show or late cancellation will result in a $60 fee and possibly case closure. I will help to transition any closed case to another provider at the request of the client. Please give a **minimum of forty-eight (48) hours notice** if you must cancel your reserved time to allow for rescheduling time. You will be required to pay $60 for a missed appointment not cancelled at least forty-eight (48) hours prior to your appointment time. If you come to your therapy session without your copayment, you will not be allowed to stay and will be charged a $60 fee for that missed session.

Fees and Payments
My fee is $125 per a 45-minute session.* ***Copayments and deductibles are due at the commencement of the therapy session.***
Most insurance companies contract and reimburse for a maximum of **45-minute therapy sessions.*

Employee Assistance Programs (EAP)
Clients utilizing their employee assistance program are not responsible for session fees covered by their employer's EAP contract. Clients choosing to continue in therapy services upon completion of their EAP benefits will be fully responsible for session fees. The cancellation policy applies to all clients including EAP clients.

Telephone and Emergency Procedures
If you need to contact me between sessions to schedule a session or for other administrative issues, please leave a message on voice mail or text at 317.966.8366 and I will responds as soon as possible. If a potentially life-threatening mental health emergency arises and you need immediate assistance, call 9-1-1. You may also call the USA National Suicide Hotline toll free 24 hours/7 days a week: 1.800.SUICIDE (1.800.784.2433) or 1.800.273.TALK (1.800.273.8255).

Authorization for Release of Protected Health Information (PHI)
Mental Health Record

1. Client Information

Client last name _____ First name _____ MI _____ Date of birth _____

Client address _____
Street City State Zip

Client home phone _____ Work phone _____ Cell phone _____

2. Recipient Authorization

I, _____, do hereby authorize __LAUREL HICKS, LCSW_____ to release a copy of my mental health record
Client name or representative Provider or service

to the person or facility below. *(Please note: A fee may be required for this release.)*

Name of person or facility to receive mental health record _____

_____
Street City State Zip Phone

3. Information to be Released

This request does not apply to release of psychotherapy notes

☐ My entire mental health record ☐ Only those portions pertaining to:

_____

4. Purpose of Information Release

☐ Further mental health care ☐ Payment of insurance claim ☐ Legal investigation ☐ Applying for insurance ☐ Vocational rehab, evaluation

☐ Disability determination ☐ At the request of the individual ☐ Other (specify): _____

5. Inclusion of Privileged Information

I understand that if my record contains information concerning alcohol or drug abuse/ treatment that is protected by Federal Regulations 42 CFR, Part 2, or information concerning abortion, HIV testing and related information, AIDS or AIDS-related condition, genetic testing, STDs, domestic/sexual abuse, or developmental disabilities that is protected by MGL c111 §70, such information will be included in this disclosure.

If you do **not** wish to have released any of the categories of information described above, please specify: _____

_____

6. Patient Rights and Privacy

I understand that I do not have to sign the authorization in order to receive treatment or payment, or to enroll or be eligible for benefits. I understand that I may revoke this authorization by providing a written statement to Laurel Hicks, LCSW, except to the extent that Mental Health Service has already completed action on it.

I understand that protected health information disclosed pursuant to this authorization may be re-disclosed by the recipient(s) to other individuals or organizations that are not subject to privacy protection laws. I also hereby release Laurel Hicks, LCSW from all legal responsibilities and liabilities that may arise from the release of such protected health information.

I understand this authorization is valid for the disclosures of the specified protected health information to the recipient above for a period of six months, and it automatically expires six months after the date this form is executed.

7. Signature of client or personal representative: _____ Date _____

Personal representative, print and sign name: _____

If signed by a personal representative, state your relationship to client and/or reason and legal authority for signing:

Client is: Legal authority:

☐ minor ☐ parent ☐ incompetent ☐ legal guardian ☐ disabled ☐ deceased ☐ next of kin of deceased